

HEALTH QUESTIONNAIRE
(With Physician's Report)

STD. 610 (REV. 7-96) (Page 1 of 4)

STATE LAW AND THE AMERICANS
WITH DISABILITIES ACT REQUIRE APPLICANTS
TO FILL IN QUESTIONS ON PAGES 1 AND 2 OF THIS FORM
ONLY AFTER A JOB OFFER HAS BEEN MADE

DATE JOB OFFER MADE

SOCIAL SECURITY NUMBER (Optional - See Privacy
Statement below.)**THIS AREA TO BE COMPLETED BY HIRING AGENCY - COMPLETED QUESTIONNAIRE WILL BE RETURNED TO HIRING AGENCY**

APPLICANT NAME (Last) (First) (Middle)			HIRING AGENCY NAME	
APPLICANT ADDRESS (Number and Street) (City) (State) (ZIP Code)			AGENCY ADDRESS	
CLASS TITLE AND POSITION NUMBER OF VACANCY			HIRING MANAGER'S NAME AND TELEPHONE NUMBER	
APPOINTMENT TYPE <input type="checkbox"/> PERMANENT <input type="checkbox"/> TAU <input type="checkbox"/> LIMITED TERM (If reinstatement, enter dates of previous State employment) <input type="checkbox"/> REINSTATEMENT			DESIRED APPOINTMENT DATE CERTIFICATION NUMBER	
			CURRENT OCCUPATION	

THIS AREA TO BE COMPLETED BY THE APPLICANT**DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN****SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.**

Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form.

BIRTH DATE		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	HEIGHT	WEIGHT
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For questions 1-31, have you ever had or do you have the following:		ITEM		YES	NO
1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma	YES	NO	27. Gall bladder trouble		
2. Residuals of poliomyelitis			28. Kidney or bladder trouble		
3. Hepatitis, jaundice, or other liver ailments			29. Shortness of breath		
4. Cancer, malignant tumor, or cysts			30. Any speech impairment		
5. Diabetes or sugar in urine			31. History of addiction to drugs or alcohol		
6. Pernicious anemia, leukemia, or other blood disorder or ailment			32. Do you wear or have you ever worn glasses?		
7. Mental illness or nervous breakdown			33. Do you or have you ever worn contact lenses?		
8. Any disorder of the nervous system			34. Have you had any eye injury, surgery, or disease?		
9. Seizure disorder or loss of consciousness			35. Are you blind in one eye?		
10. Severe headaches or migraine			36. Are you blind in both eyes?		
11. Heart trouble--including circulatory disease			37. Do you wear a hearing aid or have you had at any time a problem with your hearing?		
12. Rheumatic fever			38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2.		
13. Any defect of bones or joints, including amputations, dislocations, or broken bones			39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address.		
14. Rheumatism, arthritis, or bursitis			40. Are you taking any medication now or in the last 12 months? If yes, what?		
15. Back pain or back injury			41. Have you ever been hospitalized? If yes, list reason and date of hospitalization?		
16. Head injury			42. a. Have you had an illness or injury which caused you to lose time from work?		
17. Any problems with hips, knees, ankles, or feet			b. Does this illness or injury continue to limit your ability to perform certain types of work?		
18. Any problems with hands, elbows, or shoulders			43. Have you ever had any other illness, injury or physical condition not named above (exclude minor problems such as colds, flu, etc.)?		
19. Fainting spells or dizziness					
20. Skin trouble					
21. Allergies					
22. Sensitivity to dust or smoke					
23. High or low blood pressure					
24. Varicose veins					
25. Stomach or duodenal ulcer or other bowel problem					
26. Rupture or hernia					

(Continue on reverse.)


PRIVACY NOTICE

Official Responsible: Medical Officer, State Personnel Board, P. O. Box 944201, Sacramento, CA 94244-2010; **Authority:** Government Code Section 18931; **Purpose:** The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; **Providing Information:** Medical clearance is required prior to employment in State service; **Effects of Not Providing Information:** Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous; **Access:** Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

HEALTH QUESTIONNAIRE**(With Physician's Report)**

STD. 610 (REV. 7-96) (Page 2 of 4)

Please write your own account and your own evaluation of all items to which you have answered "YES" to the prior questions. Include DIAGNOSIS, DATE OF ONSET, YOUR PRESENT CONDITION AS YOU EVALUATE IT and what accommodations to your limitations, if any, you feel you may require to perform satisfactorily the duties of the position for which you are applying without endangering the health and safety of yourself or others. **Return this completed form to the hiring agency unless (1) advised otherwise by the hiring agency, or (2) for strong personal reasons you prefer to send it directly to the Medical Officer, State Personnel Board, P. O. Box 944201, Sacramento, CA 94244-2010. If you choose the latter, be sure to notify the hiring agency you have done so.**

NAMES OF DOCTORS WHO WERE CONSULTED FOR TREATMENT OF CONDITION DESCRIBED ABOVE	DOCTORS' ADDRESSES		
CERTIFICATION: I certify that I have provided true and complete information concerning my health. (Any misrepresentation or material omission may be cause for dismissal.)	APPLICANT'S SIGNATURE 	DATE SIGNED	TELEPHONE NUMBER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: Any licensed physician, other licensed practitioner, hospital, clinic, or other medically-related facility, United States Veterans Administration, military or selective services which are in the possession of medical records pertaining to the person named on the reverse of this form.

In order to assist in determining my eligibility for employment with the State of California, I authorize you to copy and to transmit to the medical office listed below, any and all data and records concerning my physical and mental health with the following exceptions:

This authorization shall be valid for a period of 90 days after the date of my signature or earlier if revoked by me in writing to the State Personnel Board.

FROM: MEDICAL OFFICER
STATE PERSONNEL BOARD
P. O. BOX 944201
SACRAMENTO, CA 94244-2010

I have a right to receive a copy of this authorization upon request.

APPLICANT'S SIGNATURE

DATE SIGNED



APPLICANT--DO NOT WRITE BELOW THIS LINE--DELEGATED AUTHORITY OR STATE PERSONNEL BOARD MEDICAL OFFICER ONLY

REVIEWER

☐

APPROVED

☐

QUESTIONABLE--Subject to Proper Placement (STPP)

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DISAPPROVED

IF DISAPPROVED, STATE JOB-RELATED RATIONALE; IF STPP, STATE RESTRICTIONS

REVIEWING AUTHORITY'S SIGNATURE



DATE SIGNED

TELEPHONE NUMBER

REVIEWING AUTHORITY'S NAME (Typed or printed)

HEALTH QUESTIONNAIRE
(With Physician's Report)

STD. 610 (REV. 7-96) (Page 3 of 4)

(To be completed by a licensed physician and surgeon only after a job offer has been made)

TO THE PHYSICIAN: The attached Health Questionnaire must be completed and submitted to you by the person whose name appears below. It is intended to assist you in conduct of the examination. You are requested to complete the medical examination report. **The Hiring Agency is responsible for payment of the fee.** See page 4 for instructions.

APPLICANT'S SOCIAL SECURITY NUMBER (Optional)

ALL ITEMS BELOW ARE MANDATORY--COMPLETED REPORT SHOULD BE RETURNED TO HIRING AGENCY

APPLICANT'S NAME (Last) (First) (Middle)			HIRING AGENCY NAME		
APPLICANT'S ADDRESS (Number and Street) (City) (State) (ZIP Code)			AGENCY ADDRESS		
CLASS TITLE AND POSITION NUMBER OF VACANCY			HIRING MANAGER'S NAME AND TELEPHONE NUMBER		
APPOINTMENT TYPE <input type="checkbox"/> PERMANENT <input type="checkbox"/> TAU <input type="checkbox"/> LIMITED TERM <input type="checkbox"/> PEACE OFFICER (If reinstatement, enter dates of previous State employment) <input type="checkbox"/> REINSTATEMENT			DESIRED APPOINTMENT DATE		CERTIFICATION NUMBER
			CURRENT OCCUPATION		

DOCTOR: Write comments on any positive or negative findings for evaluation of applicant. (If more space is needed, use reverse of this form and/or a separate sheet of paper.) Examine color vision only when required in Minimum Qualifications.

1. HEIGHT	2. VISION <input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACT LENSES					2A. COLOR VISION TESTING REQUIRED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> ISHIHARA									
WEIGHT (Without heavy clothing or shoes)			UNCORRECTED		CORRECTED		3. HEARING (Ordinary conversation at 15 feet considered normal)		AUDIOMETRY (If done)						
			NEAR	DISTANT	NEAR	DISTANT	RIGHT	LEFT		500	1000	2000	3000	4000	
	Right 20/						/ 15	/ 15	Right						
	Left 20/								Left						
	Both 20/						HEARING AID USED <input type="checkbox"/> YES <input type="checkbox"/> NO								
4. HEAD (Eyes, ears, nose, mouth, throat)									5.(A) RESTING PULSE RATE			5.(B) BLOOD PRESSURE			
6. LUNGS (Breath sounds, rales)						7. HEART (enlargement, rhythm, sounds) AND CIRCULATORY SYSTEM									
8. NERVOUS SYSTEM (Reflexes, motor strength, atrophy, sensory changes, or any abnormal reflexes)															
9. ABDOMEN (G.I. system, liver, spleen, masses, scars, herniae, etc.)									HERNIA						
10. GENITOURINARY SYSTEM INCLUDING KIDNEYS									11. RECTAL Fissure Fistual Hemorrhoids						
12. SPINE (Deformity, tenderness, range of motion)									13. EXTREMITIES (Strength, range of motion, deformities, atrophy or sensory changes)						
14. SKIN AND LYMPHATICS, SIGNIFICANT SCARRING									15. VARICOSE VEINS (Severity)						
16. URINALYSIS Specific Gravity Albumin Sugar						17. ANY WORK LIMITATION (Specify)									
18. PSYCHIATRIC EVALUATION (Any mental disorder observed)															
19. PHYSICIAN'S SIGNATURE (Required)															
DATE SIGNED						PHYSICIAN'S NAME AND ADDRESS -(Required - Please print)				TELEPHONE NUMBER (Required)					
										PHYSICIAN'S TAXPAYER I.D. NUMBER (FEIN or SSA number- Required)					

HEALTH QUESTIONNAIRE
(With Physician's Report)

STD. 610 (REV. 7-96) (Page 4 of 4)

NOTICE TO PHYSICIANS AND CLINICS

The State of California requires preplacement physical examinations for certain classes of employment. The State also has many employees who are required to have a physical examination at the time of renewal of their **Class I** or **II** driver's license, when the possession of the license is required for the position.

If the hiring agency is not identified, do not perform the examination. The State Personnel Board does not have the authority to pay for examinations.

REPORTS

The medical report should be sent to the **Hiring Agency** shown on **Page 1**, unless you are requested by the person examined to mail this medical report directly to the **State Personnel Board Medical Office, P. O. Box 944201, Sacramento, California 94244-2010**.

BILLINGS

Please send your bill for this examination to the **Hiring Agency** as indicated on **Page 1**. Include your **Federal Employer Identification Number** or **Social Security Number** for tax reporting purposes.

The **State Hiring Agency** will pay the fee for this **Medical Examination Report** up to a maximum determined by the **Department of Health Services** and set forth in the **State Administrative Manual (Section 0190.1)**. The current fee allowance may be obtained from the **Hiring Agency** shown on **Page 1**. If there should be additional studies or examinations required for more complete evaluation of the individual, these examinations will be at the expense of the applicant.